Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

MEMORANDUM

Date: December 20, 2019

To: Prospective Applicants

From: Anna Starr, Assistant Bureau Chief
Bureau of Maternal, Child and Family Health
Ohio Department of Health

Subject: Notice of Availability of Funds – Competitive Solicitation for State Fiscal Year 2021 (July 1, 2020 - June 30, 2021) Sickle Cell Services Program

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The Ohio Department of Health (ODH), Bureau of Maternal, Child and Family Health, announces the availability of grant funds to support activities of the **Sickle Cell Services Program – Statewide Family Support Initiative**.

Qualified applicants for grant funds under this initiative are any community-based 501 (c) (3) agency organized for and capable of ensuring the provision of **statewide** *education, awareness and community engagement activities* for individuals and families at risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies and the professionals who serve them. Funding consideration will be given to the applicant agency that demonstrates capability, experience and expertise in these three (3) grant priority areas and whose programmatic activities address the Goals of the Sickle Cell - Statewide Family Support Initiative. **Only one agency will be funded in the state**.

This is a competitive solicitation. **A Notice of Intent to Apply for Funding (NOIAF – Appendix A) must be submitted by Tuesday, January 07, 2020** so access to the application via the internet website "ODH Application Gateway" can be established.

To be eligible for funding, all applicant agency must be a local public or non-profit agency and have the capacity to accept electronic funds transfer (EFT). If an applicant agency needs GMIS access, then a GMIS access form must be submitted (**Appendix B).**

Potential applicants are encouraged to participate in an Information session to be held via conference call on **Friday, January 3, 2020 from 11:00 a.m. to 12:30 p.m. EST**. The conference call is being offered to allow potential applicants the opportunity to discuss the solicitation and learn about the elements of a successful application. Refer to the solicitation for more information regarding accessing the Information Session.

All applications, including any required attachments, must be completed and received by ODH electronically via GMIS by **4:00 p.m. on Monday, February 3, 2020**. Applications received after the due date will not be considered for review.

Should you have any questions, please contact Cheryl Jones, Sickle Cell Services Program Coordinator by e-mail at cheryl.jones@odh.ohio.gov.

Ohio
Department of Health

ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

BUREAU OF
Maternal, Child and Family Health

SICKLE CELL SERVICES PROGRAM
SICKLE CELL - STATEWIDE FAMILY SUPPORT INITIATIVE
SOLICITATION
FOR
FISCAL YEAR 2021
(07/01/2020 – 06/30/2021)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION
100% Deliverable Funding

Revised 02/11/2019
For grant starts 10/1/2019 and thereafter

Table of Contents

F. Other Program Documents:

- Attachment #1 – Public Health Impact Statement Summary
- Attachment #2 – Public Health Impact Statement of Support from Local Health Districts
- Attachment #3 – Biographical Sketch
- Attachment #4 – Position Descriptions
- Attachment #5 – Deliverable-Objectives Work Plan
- Attachment #6 – Letter of Documentation
- Attachment #7 – Client Incentive Form

I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required components including an electronic portion submitted via the Internet website "ODH Application Gateway" and various paper forms and attachments. All the required components of a specific application must be completed and submitted by the application due date. **If any of the required components are not submitted by the due date indicated in sections D, G and R, the entire application will not be considered for review.**

This is a competitive solicitation; a Notice of Intent to Apply for Funding (NOIAF – **Appendix A**) must be submitted by **January 07, 2020** so access to the application via the Internet website "ODH Application Gateway" can be established.

NEW AGENCIES ONLY or if UPDATES are needed: For non-profit agencies, the NOIAF must be accompanied by proof of non-profit status. Both non-profit and local public agencies must submit proof of liability coverage. Potential applicants and current subrecipients are required to maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information is maintained on the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

The application summary information is provided to assist your agency in identifying funding criteria:

A. Policy and Procedure: Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (OGAPP) manual and updates in policies that have been posted on the GMIS Bulletin Board. This manual and GMIS Bulletin Board policy updates must be followed to ensure adherence to the rules, regulations and procedures for preparation of all Subrecipient applications. The OGAPP manual is available on the ODH website: *https://odh.ohio.gov/wps/portal/gov/odh/home*. (Click on Grants/Contracts, ODH Grants, Grants Administrative Policies and Procedures Manual (OGAPP) or copy the following link into your web browser: *https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/resources/grants-administrative-policies-and-procedures-manual*.

Please refer to Policy and Procedure updates found on the GMIS bulletin board.

All budget justifications must include the following language and be signed by the agency head listed in GMIS. Please refer to the budget justification examples listed on the GMIS bulletin board.

Budget Justification Certification language

- Subrecipient understands and agrees that it must follow the federal cost principle that applies to its type of organization (2 CFR, Part 225; 2 CFR, Part 220; or 2 CFR, Part 230).
- Subrecipient's budgeted costs are reasonable, allowable and allocable under OGAPP and federal rules and regulations.
- The OGAPP and the rules and regulations have been read and are understood.
- Subrecipient understands and agrees that costs may be disallowed if deemed unallowable or in violation of OGAPP and federal rules and regulations.
- The appropriate programmatic and administrative personnel involved in this application are aware of agency policy in regard to subawards and are prepared to establish the necessary inter-institutional agreements consistent with those policies.
- Subrecipient agrees and understands that costs incurred in the fulfillment of the Deliverables must be allowable under OGAPP and federal rules and regulations to qualify for reimbursement.

B. Application Name: Sickle Cell-Statewide Family Support Initiative

C. Purpose: To support the provision of **statewide** education, awareness and community engagement activities for individuals (adults) and families at risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies.

D. Qualified Applicants*:* All applicants must be a local public or non-profit agency. Qualified applicants include any community based 501 (c) (3) agency organized for and capable of ensuring the provision of **statewide** public and professional under three (3) grant priorities: statewide education, awareness and community engagement and empowerment activities related to sickle cell disease, sickle cell trait and other hemoglobinopathies. Funding consideration will be given to the applicant agency that demonstrates capability, experience and expertise in these grant priority areas and whose programmatic activities address the Goals of the Sickle Cell - Statewide Family Support Initiative. **Only one applicant agency will be funded in the state.**

All applicants must have the capacity to accept an electronic funds transfer (EFT). If an applicant agency needs GMIS access, then a GMIS access form must be submitted (**Appendix B**).

Support of clinical services is not a funding priority for this Initiative.

Sickle Cell Program Application Guidance: *The Project Director (see below) for the Sickle Cell -Statewide Family Support Initiative must be listed as a "User" on the Project Contacts page in GMIS.*

Applicants must also meet the additional programmatic requirements listed below to quality for funding:

1. Must have a history of effective collaboration and cooperation within the state. Shared or cooperative projects involving more than one agency/organization which enhances the

ability to cut across geographic or service system boundaries are encouraged; and

2. Must have the necessary administrative, professional and technical staff in place for the effective operation of the project. The **core team staff** must have experience and/or expertise in the provision of sickle cell services and, at a minimum, include: **Project Director, Regional Outreach Educator and Medical Advisor (Appendix E).**

The following entities are <u>ineligible</u> for funding consideration:

- Individuals;
- National organizations;
- Facilities with a post office box as their only address and/or office phone number;
- Facilities applying for the sole purpose of acquiring funds to supplement existing programs without any plan for enlarging their scope of work;
- Facilities requesting funds to replicate activities currently funded by ODH or other funding sources;
- Facilities requesting funds under this initiative to pay for medical services and/or personnel that can be covered by 3rd party payers or other resources; and
- Facilities that <u>concurrently</u> apply for funds under the ODH Sickle Cell - Statewide Family Support Initiative and the ODH Sickle Cell Initiative.

The following criteria must be met for grant applications to be eligible for review:

1. Applicant does not owe funds to ODH and has repaid any funds due within 45 days of the invoice date.
2. Applicant has not been certified to the Attorney General's (AG's) office.
3. Applicant has submitted application and all required attachments by **4:00 p.m. on Monday, February 3, 2020.**

E. Service Area: The applicant will provide **<u>statewide</u>** services as identified in the Goals of the Solicitation.

F. Number of Grants and Funds Available: The ODH Sickle Cell Services Program grants are comprised of funds generated from a portion of the state Newborn Screening Fee. Only one (1) applicant will be funded in the state. The total grant funding available for the SFY 2021 budget period (07/01/2020 to 06/30/2021) is anticipated to be approximately $90,000.00.

*No grant award will be issued for less than **$30,000**. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.*

<u>Sickle Cell Program Application Guidance</u>*: The award subrecipient may subcontract with other entities for implementation of parts of the grant. Collaboration between entities that are invested in the provision of sickle cell services is strongly recommended. The applicant agency must assume an oversight role for those entities with whom they subcontract.*

G. Due Date: All parts of the application, including any required attachments, must be completed and received by ODH electronically via GMIS or via ground delivery at Cheryl Jones, ODH Sickle Cell Services Program, 246 N. High St., Columbus, Ohio 43215 by **4:00 p.m. by Monday, February 3, 2020.** Applications and required attachments received after

this deadline will not be considered for review.

Contact Cheryl Jones, Sickle Cell Services Program Coordinator by e-mail at cheryl.jones@odh.ohio.gov or (614) 728-6787 with any questions.

H. Authorization: Authorization of funds for this purpose is contained in Amended Substitute House Bill 166.

I. Goals: In releasing funds for this initiative, the goals of the ODH Sickle Cell Services Program are to:

A. Increase the visibility of sickle cell services and resources in the state of Ohio through implementation of statewide public and professional education and awareness activities;

B. Engage the community to increase the knowledge and support of Ohio individuals (young adult and adult) and families at risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies;

C. Promote national, statewide and regional collaboration of groups, programs and organizations that provide information, services and linkages to Ohio individual and/or families impacted by sickle cell disease and other hemoglobinopathies; and

D. Integrate cultural, linguistic, health literacy and other health communication elements into their policies, guidelines, contracts and trainings.

J. Program Period and Budget Period: The program period will begin 07/01/2020 and end on 06/30/2024. The budget period for this application is 07/01/2020 through 06/30/2021.

K. Public Health Accreditation Board (PHAB) Standard(s): This grant program will address the following PHAB Standards:

- **Standard 3.2**: Provide information on public health issues and public health functions through multiple methods to a variety of audiences
  - **Measure 3.2.1 A** – Information on public health mission, roles, processes, programs and interventions to improve the public's health provided to the public.
  - **Measure 3.2.5 A** – Information available to the public through a variety of methods.
  - **Measure 3.2.6 A** – Accessible, accurate, actionable and current information provided in culturally sensitive and linguistically appropriate formats for target populations served by the health department.
- **Standard 4.1**: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.
  - **Measure 4.1.1 A** – Establishment and/or engagement and active participation in a comprehensive community health partnership and/or coalition; or active participation in several partnership or coalitions to address specific public health issues or populations.

Guidance regarding the PHAB standards is available at the following website: http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf

L. Public Health Impact Statement: All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.

1. *Public Health Impact Statement Summary* - Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, **not to exceed one page**, must include:

   - The PHAB Standard(s) to be addressed by grant activities;
   - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) of the target population and the geographic area in which they live (e.g., census tracts, census blocks, block groups);
   - A summary of the services to be provided or activities to be conducted; and
   - A plan to coordinate and share information with appropriate local health districts.

   The applicant must submit the above summary as part of the grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards (**Attachment #1**).

2. *Public Health Impact Statement of Support* - Include with the grant application a statement of support from the local health districts, if available. If a statement of support from the local health districts is not obtained, indicate that point when submitting the program summary with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support should be submitted from at least one local health district, if available (**Attachment #2**).

   A listing of health districts is available at the following website:
   https://odh.ohio.gov/wps/portal/gov/odh/find-local-health-districts

   Sickle Cell Program Application Guidance: *Please use Google Chrome to access the listing of local health districts to ensure proper functionality.*

3. *Evidence of Health Equity Strategies*

   The ODH is committed to the elimination of health disparities and health inequities. All applicants are required to:

   1) Identify specific groups who experience a disproportionate burden of disease, health condition or health outcome targeted by this solicitation.

   2) Identify specific social and environmental conditions (social determinants of health) associated with health disparities and health inequities. This must be based on data and include geographic reference points (i.e., census tracts, census block groups) to specify where program activities are focused.

   3) Identify measurable health equity targets to be achieved through program activities. This information must also be supported by data.

4) Outline specific evaluation strategies to measure the impact of program activities to decrease and/or eliminate health disparities and health inequities.

5) Link proposed activities to health equity strategies identified in local, state or national planning documents. These documents include, but not limited to, current Healthy People goals and objectives; local Community Health Assessments; State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; The Health Opportunity and Equity (HOPE) Initiative.

6) The above items should be explicitly incorporated into key components of the application (i.e., Goals, Program Narrative, Objectives, Deliverables and Review Criteria). The applicant cannot decide where to insert this information. Care should be taken to avoid repetition to keep the responses focused and specific.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

The following information is provided to explain key health equity concepts and terms.

Racial and ethnic minorities, people with disabilities, the LGBTQ community and Ohio's economically disadvantaged residents do not have the same opportunities as other groups to achieve and sustain optimal health. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people live, work and play. Health disparities are unnatural and occur because of low socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, safe housing, quality education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health (SDOH).** SDOH are the root cause of health disparities. The systematic nature of health disparities is considered unjust and is referred to as **health inequities**. The ability of everyone to have the same opportunity to achieve the best health possible is referred to as **health equity**. Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to advancing health equity.

M. GMIS Health Equity Module (There are some functionality issues in GMIS and this module may not function properly. Applications can still be submitted without this being marked complete):

1) The GMIS Health Equity Module links important program interventions in grant proposals to health equity strategies identified in local, state or national strategies. These include, but are not limited to, the most current Healthy People goals and objectives; health equity targets in the State Health Improvement Plan (SHIP); National Stakeholder Strategy for Achieving Health Equity; Ohio Health Opportunity Index and/or the Health Opportunity and Equity (HOPE) Initiative. **Applicants are required to select the goals and strategies from the module that best reflect how their particular grant proposal**

addresses health disparities and/or health inequities. Applicants can choose more than one goal and/or strategy.

N. Human Trafficking: The ODH is committed to the elimination of human trafficking in Ohio. If applicable to the subrecipient program, ODH will give priority consideration to those subrecipients who can demonstrate the following:

a. Victims of human trafficking are included in your agency's target population:
   1. At-risk population
   2. Mental health population
   3. Homeless population

b. Agency promotes the expansion of services to identify and serve those affected by human trafficking.

__Applicable _X_ **Not Applicable to the Sickle Cell-Statewide Family Support Initiative**

O. Appropriation Contingency: An award made through this program is contingent upon the availability of funds for this purpose. **The subrecipient agency must be prepared to support the costs of operating the program in the event of a delay in grant payments.**

P. Programmatic, Technical Assistance and Authorization for Internet Submission: Agencies will receive their authorization after the posting of the Solicitation to the ODH website and the receipt of the NOIAF. Please contact Cheryl Jones, Sickle Cell Services Program Coordinator at cheryl.jones@odh.ohio.gov or (614) 728-6787 for questions regarding the Solicitation.

Information Session

An Information Session is being offered to allow potential applicants the opportunity to discuss the ODH Sickle Cell Initiative Competitive Solicitation and learn the elements of a successful application. Attendance is recommended, but not required for submitting an application.

The Information Session will be held via conference call on **Friday, January 3, 2020 from 11:00 to 12:30 a.m. EST**. The conference call toll free number is 1-855-405-1648 and the meeting ID is 29564#.

Sickle Cell Program Application Guidance: *Please note Sickle Cell Program staff are unable to assist with the actual writing of applications or critiques of application drafts during the Competitive cycle.*

Q. Acknowledgment: An Application Submitted status will appear in GMIS that acknowledges ODH system receipt of the application submission.

R. Late Applications: GMIS automatically provides a time and date system for grant application submissions. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, February 3, 2020 at 4:00 p.m.**

Applicants should request a legibly dated postmark or obtain a legibly dated receipt from the

U.S. Postal Service or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit (GSU), via the front desk at 246 N. High St., Columbus, Ohio 43215; but they must be delivered by **4:00 p.m**. on the application due date. Fax attachments will not be accepted**. GMIS applications and required application attachments received late will not be considered for review.**

S. Successful Applicants: Successful applicants will receive official notification in the form of a Notice of Award (NOA). The NOA, issued over the signature of the Director of the Ohio Department of Health, allows for expenditure of grant funds.

T. Unsuccessful Applicants: Within 30 days after a decision to disapprove or not fund a grant application, written notification, issued over the signature of the Director of Health, or his designee, shall be sent to the unsuccessful applicant.

U. Review Criteria: All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:

1. Contributes to the advancement and/or improvement of the health of Ohioans;
2. Is response to policy concerns and program objectives of the initiative/program/activity got which grant dollars are being made available;
3. Is well executed and is capable of attaining program objectives;
4. Describe Specific, Measurable, Attainable, Realistic & Time-Phased (S.M.A.R.T.) objectives, activities, milestones, and outcomes with respect to time-lines and resources;
5. Estimates reasonable cost to the ODH, considering the anticipated results;
6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and he applicant organization has adequate facilities and personnel;
7. Provides and evaluation plan, including a design for determining program success;
8. Is responsive to the special concerns and program priorities specified in the Solicitation;
9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
10. Has demonstrated compliance with OGAPP;
11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the disease; health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and
12. Describe activities which support the requirements outlined in section I. thru M. of this Solicitation.

Program-Specific Review Criteria

In addition to the criteria listed above, applications will be reviewed based on the degree to which they specifically address the requirements of the Sickle Cell Initiative. Responses to the Solicitation, which are determined to be complete and in compliance with these requirements, will be reviewed in accordance with the Point Values on the Application Review Form (**Appendix D**).

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given Solicitations; **There will be no appeal of the Department's decision.**

V. Freedom of Information Act: The Freedom of Information Act (5 U.S.C.552) and the

associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service; 34 CFR Part 5 for funds from the U.S. Department of Education or 7 CFR Part 1 for funds from the U.S. Department of Agriculture.

W. Ownership Copyright: Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

"This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Maternal, Child and Family Health, Sickle Cell Services Program."

X. Reporting Requirements: Successful applicants are required to submit Subrecipient program and expenditure reports. Reports must adhere to the requirements of the OGAPP manual. Reports must be received in accordance with the requirements of the OGAPP manual and this Solicitation; before the department will release any additional funds.

Note: Failure to ensure the quality of reporting by submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports:** Subrecipient Program Performance Reports **must** be completed and submitted **via GMIS** by the following dates:

Monthly Program Performance Report

Period	*Report Due Date*
July 1 – 31, 2020	*August 10, 2020*
August 1 – 31, 2020	*September 10, 2020*
September 1 – 30, 2020	*October 10, 2020*
October 1 – 31, 2020	*November 10, 2020*
November 1 – 30, 2020	*December 10, 2020*
December 1 – 31, 2020	*January 10, 2021*
January 1- 31, 2021	*February 10, 2021*
February 1 – 28, 2021	*March 10, 2021*

March 1- 31, 2021	*April 10, 2021*
April 1 – 30, 2021	*May 10, 2021*
May 1 – 31, 2021	*June 10, 2021*
June 1 – 30, 2021	*July 10, 2021*

Quarterly Program Performance Report

Period	*Report Due Date*
July 1 - September 30, 2020	*October 10, 2020*
October 1 – December 31, 2020	*January 10, 2020*
January 1 – March 31, 2021	*April 10, 2021*
April 1 – June 30, 2021	*July 10, 2021*

2. Subrecipient Annual Report Worksheet **must** be completed and submitted **via GMIS** by the following date:

Period	*Report Due Date*
July 1, 2019 – June 30, 2020	*April 10, 2021*

3. Subrecipient Monthly Combined Education Event Reporting **must** be completed and submitted in the format specified by ODH (e.g., Survey Monkey) by the following dates:

Period	*Report Due Date*
July 1 – 31, 2020	*August 10, 2020*
August 1 – 31, 2020	*September 10, 2020*
September 1 – 30, 2020	*October 10, 2020*
October 1 – 31, 2020	*November 10, 2020*
November 1 – 30, 2020	*December 10, 2020*
December 1 – 31, 2020	*January 10, 2021*
January 1- 31, 2021	*February 10, 2021*
February 1 – 28, 2021	*March 10, 2021*
March 1- 31, 2021	*April 10, 2021*
April 1 – 30, 2021	*May 10, 2021*
May 1 – 31, 2021	*June 10, 2021*
June 1 – 30, 2021	*July 10, 2021*

4. Subrecipient Quarterly Combined Education Event Reporting **must** be completed and submitted in the format specified by ODH (e.g., Survey Monkey) by the following dates:

Period	*Report Due Date*
July 1 - September 30, 2020	*October 10, 2020*
October 1 – December 31, 2020	*January 10, 2020*
January 1 – March 31, 2021	*April 10, 2021*
April 1 – June 30, 2021	*July 10, 2021*

Program reports that do not include required attachments (non-Internet submitted) will not be approved. All program report attachments must clearly identify the authorized program name and grant number.

Sickle Cell Program Application Guidance: *The formats for submission of the SFY 2021 Program Performance Report (and any required attachments), Combined Education Event Reporting and Annual Report Worksheet will be provided to the successful applicant subsequent to official award notification from ODH.*

In addition to submission of the above–listed reports, subrecipient staff *(applicable core team staff as defined by this Solicitation)* are **required** to participate in the following ODH Sickle Cell Services Program meetings and/or conference calls:

Subrecipient Communication with ODH	***Meeting Dates***
Project Directors *Applicable Core Team Staff*	*September 2020* *December 2020* *March 2021* *June 2021*

b. Subrecipient Reimbursement Expenditure Reports: Subrecipients can choose monthly or quarterly reimbursement (expenditure report submission) from ODH (please check the reimbursement type on the attached NOIAF). Please note that no changes can be made to the reimbursement type during the fiscal year once the project numbers have been established in GMIS. Subrecipient Monthly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Period	*Report Due Date*
July 1 – 31, 2020	*August 10, 2020*
August 1 – 31, 2020	*September 10, 2020*
September 1 – 30, 2020	*October 10, 2020*
October 1 – 31, 2020	*November 10, 2020*
November 1 – 30, 2020	*December 10, 2020*
December 1 – 31, 2020	*January 10, 2021*
January 1- 31, 2021	*February 10, 2021*
February 1 – 28, 2021	*March 10, 2021*
March 1- 31, 2021	*April 10, 2021*
April 1 – 30, 2021	*May 10, 2021*
May 1 – 31, 2021	*June 10, 2021*
June 1 – 30, 2021	*July 10, 2021*

Subrecipient Quarterly Reimbursement Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates: **(please see example below)**

Period	*Report Due Date*
July 1 - September 30, 2020	*October 10, 2020*
October 1 – December 31, 2020	*January 10, 2021*
January 1 – March 31, 2021	*April 10, 2021*
April 1 – June 30, 2021	*July 10, 2021*

Sickle Cell Program Application Guidance: *The format for the Expenditure Report "Deliverables Reimbursement Form" will be provided to the successful applicant subsequent to official award notification from ODH.*

Note: Obligations not reported on the final monthly or 4th quarter expenditure report will not be considered for payment with the final expenditure report.

c. Final Expenditure Reports: A Subrecipient Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS by 4:00** p.m. on or before **August 5, 2021.** The information contained in this report must reflect the program's accounting records and supportive documentation. Any cash balances must be returned with the Subrecipient Final Expense Report. The Subrecipient Final Expense Report serves as an invoice to return unused funds.

Submission of the Monthly/Quarterly and Final Subrecipient Expenditure reports via the GMIS system indicates acceptance of OGAPP. Clicking the "Approve" button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations.

Y. Special Condition(s): A Special Conditions link is available for viewing and responding to special conditions within GMIS. The 30-day time period, in which the subrecipient must respond to special conditions will begin when the link is viewable. Subsequent payments will be withheld until satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied is submitted in GMIS.

Z. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Contributions to a contingency fund;
6. Entertainment;
7. Fines and penalties;
8. Membership fees -- unless related to the program and approved by ODH;
9. Interest or other financial payments (including but not limited to bank fees);
10. Contributions made by program personnel;
11. Costs to rent equipment or space owned by the funded agency;
12. Inpatient services;
13. The purchase or improvement of land; the purchase, construction or permanent improvement of any building;
14. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
15. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.

Program-Specific Unallowable Costs

16. Alcoholic beverages;
17. Client Enablers;
18. Costs associated with any work produced under this grant, including documents, data, photographs and negatives, electronic reports, records, software, source code, or other media that is not pre-approved in advance by ODH;
19. Costs associated with clinical services (with the exception of instructional supplies);
20. First class travel;
21. Food, refreshments and beverages;
22. Funds requested to reduce, replace or supplant existing applicant agency funds for sickle cell and other hemoglobinopathy services;
23. Grant-related equipment costs greater than $1,000.00 unless justified and approved by ODH;
24. Lodging, travel and meals over the current state rates (See Ohio Shared Services website for hotel rates and meals per diem at: http://ohiosharedservices.ohio.gov/TravelExpense/);
25. Office furniture (Refer to OGAPP Manual);
26. Out-of-state travel, unless prior approved by ODH (restrictions apply);
27. Promotional items (Refer to OGAPP Manual);
28. Staff development and/or training longer than one week in duration, unless prior approved by ODH;
29. Subscriptions; and
30. Unapproved educational or training activities.

Subrecipients will not receive payment from ODH grant funds used for prohibited purposes. ODH has the right to recover funds paid to Subrecipients for purposes later discovered to be prohibited.

AA. Audit: Subrecipients currently receiving funding from the ODH are responsible for submitting an independent audit report. Every subrecipient will fall into one of two categories which determine the type of audit documentation required.

Subrecipients that expend $750,000 or more in federal awards per fiscal year are required to have a single audit which meets OMB's Federal Uniform Administrative Requirements. The subrecipient must submit, a copy of the auditor's management letter, a corrective action plan (if applicable) and a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB's Federal Uniform Administrative Requirements.

Subrecipients that expend less than the $750,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. The Subrecipient must submit a copy of the audit report, the auditor's management letter, and a corrective action plan (if applicable) within 30 days of the receipt of the auditor's report, but no later than nine months after the end of the Subrecipient's fiscal year. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent to **https://harvester.census.gov/facweb/** or to the ODH, Grants Services Unit, (GSU) within 30 days. Reference: OGAPP and OMB's Omni Circular Federal Uniform Administrative Requirements regarding Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

Subrecipient audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which**:

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on subgrants passed through the ODH; and
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AB. Submission of Application

Formatting Requirements:

- Properly label each item of the application packet (e.g., Budget Narrative, Program Narrative).
- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget Narratives must be submitted in portrait orientation on 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program Narrative should not exceed 17 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12-point font.
- Forms must be completed and submitted in the format provided by ODH

The GMIS application submission must consist of the following:

Complete & Submit Via Internet

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
   - Primary Reason
   - Funding
   - Justification
   - Personnel
   - Other Direct Costs
   - Equipment
   - Contracts
   - Compliance Section
   - Summary
5. Civil Rights Review Questionnaire
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form

8. Change request in writing on agency letterhead **(Existing agency with tax identification number, name and/or address change(s).**
9. Health Equity Module
10. Public Health Impact Statement Summary (non-health department only)
11. Statement of Support from the Local Health Districts (non-health department only)
12. Attachments as required by Program
    - Attachment #1 – Public Health Impact Statement Summary
    - Attachment #2 – Public Health Impact Statement of Support from Local Health Districts
    - Attachment #3 – Biographical Sketch
    - Attachment #4 – Position Descriptions
    - Attachment #5 – Deliverable - Objectives and Work Plan
    - Attachment #6 – Letter of Documentation
    - Attachment #7 – Client Incentives Form

One copy of the following document(s) must be e-mailed to **https://harvester.census.gov/facweb/** or mailed to the address listed below:

Complete Copy & E-mail or Mail to ODH

Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)

Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
35 E. Chestnut Street
Columbus, Ohio 43215

II. APPLICATION REQUIREMENTS AND FORMAT

Agencies will receive GMIS access after the Notice of Intent to Apply for Funding for is submitted to ODH.

All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH's GMIS system indicates acceptance of OGAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of OGAPP rules and regulations in lieu of an executed Signature Page document.

A. Application Information: Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.

B. Budget: Prior to completion of the budget section, please review page 14-15 of the Solicitation for unallowable costs.

Match or Applicant Share is not required by this program. Do not include Match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the

narrative may be used to identify additional funding information from other resources.

The funded applicant must also adhere to the following budgetary restrictions:

- No funds may be reimbursed for clinical services (with the exception of instructional supplies).

1. **Primary Reason and Justification Pages:** Provide a budget justification narrative outlining how the deliverable will be met (A budget justification example can be found on the GMIS on the Bulletin Board).

   Deliverable funds may be used to support personnel, their training, travel (see OBM website) and supplies directly related to planning, organizing and conducting the initiative described in this Solicitation.

   Submit as an upload in GMIS, the following documents:

   - Biographical Sketch for all core team staff working on project deliverables. Each biographical sketch must include job information and responsibilities as they relate to the application position (**Attachment #3**).

   - Position Descriptions for all core team staff in which a biographical sketch is submitted **(Attachment #4).**

2. **Other Direct Costs:** Submit a budget for this section and the necessary form(s) to support costs for the period July 1, 2020 to June 30, 2021.

   The applicant shall retain all original fully executed contracts on file.

3. **Compliance Section:** Answer each question on this form in GMIS as accurately as possible. ***Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.***

C. Assurances Certification: Each subrecipient must submit the Assurances (Federal and State Assurances for subrecipients) form within GMIS. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive, and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the "Complete" button. By submission of an application, the subrecipient agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. **Executive Summary**

   - Identify the target population, services and programs to be offered and what agency or agencies will provide those services, burden of health disparities and health inequities.

■ Describe the public health problem(s) that the program will address.

Sickle Cell Program Application Guidance: *The Executive Summary should be no longer than two (2) pages, using the grant formatting requirements described on page 16. Each response should be referenced by the bullet point to which they correspond.*

2. Description of Applicant Agency/Documentation of Eligibility/Personnel:

■ Briefly discuss the applicant agency's eligibility to apply.

■ Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.

■ Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

■ Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describe plans for hiring and training, as necessary.

■ Delineate **all** personnel who will be directly involved in project activities.

■ Describe the relationship between program staff members, staff members of the applicant agency, and other partners and agencies that will be working on this program.

Sickle Cell Program Application Guidance: *The Description of Applicant Agency/Documentation of Eligibility/Personnel should be no longer than five (5) pages, using the grant formatting requirements described on page 16. Each response should be referenced by the bullet point to which they correspond.*

3. Problem/Need:

■ Identify and describe the local health status concern(s) that will be addressed by the program. Only restate national and state data if local data is not available. The specific health status concerns that the program intends to address may be stated in term**s** of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based. Clearly identify the target population.

■ Explicitly describe segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.

■ Include a description of other agencies/organizations, in your area, also addressing this problem/need.

Sickle Cell Program Application Guidance: *The Problem/Need should be no longer than five (5) pages, using the grant formatting requirements described on page 16. Each*

response should be referenced by the bullet point to which they correspond.

4. Methodology:

- In narrative form, identify the program goals, **S.M.A.R.T** process, impact, or outcome objectives and activities. Indicate how they will be evaluated to determine the level of success of the program.

- If health disparities and/or health inequities have been identified, describe how program activities are designed to address these issues.

- Complete a program activities time line to identify program objectives and activities and the start and completion dates for each (see **Attachment #5**).

Sickle Cell Program Application Guidance:

- *The Methodology should be no longer than five (5) pages (excluding the Deliverable-Objectives and Work Plan), using the grant formatting requirements described on page 16.*

- *The activities designed to address health disparities and health inequities submitted under the Methodology Section must correlate with the Health Equity Goals and Strategies indicated by the applicant on the GMIS Health Equity Module.*

5. Additional Requirements and/or Documentation:

- Letter of Documentation
  Each applicant must identify and provide a signed letter of documentation from the Medical Advisor that will be responsible for providing guidance and leadership to the applicant agency regarding the implementation of the three (3) grant priority areas addressed under this initiative (**Attachment #6**).

- Reporting Requirements
  Each applicant will be required to submit data reporting forms as required by ODH. These forms *include but are not limited to* (1) Program Performance Reports, (2) Combined Education Event Reporting and Annual Report Worksheet.

- Client Incentives
  Client incentives are an allowable cost for the subrecipient of the Sickle Cell – Statewide Family Support Initiative. The following client incentives are allowed: Gas cards distributed to clients/consumers for completion of or participation in an approved activity (**Attachment #7**).

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire Survey is a part of the Application Section of GMIS. Subrecipients must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA): All applicants applying for ODH grant funds are required to complete the FFATA reporting form in GMIS.

Applicants must ensure that the information contained in SAM.gov, DUN & Bradstreet and the FFATA reporting form match. ODH will hold all payments if an applicant's information does not successfully upload into the federal system.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS), register in SAM.gov and submit the information in the grant application. For information about the DUNS, go to www.dnb.com. For information about System for Award Management (SAM) go to https://beta.sam.gov/.

Information on Federal Spending Transparency can be located at www.usaspending.gov or the Office of Management and Budget's website for Federal Spending Transparency at https://www.whitehouse.gov/.

(Required by all applicants, the FFATA form is located on the GMIS Application page and must be completed in order to submit the application.)

G. **Attachment(s):** Attachments are documents which are not part of the standard GMIS application but are deemed necessary to a given grant program. **All attachments must clearly identify the authorized program name and program number.** All attachments submitted to GMIS must be attached in the "Project Narrative" section and be in one of the following formats: PDF, Microsoft Word or Microsoft Excel. Please see the GMIS bulletin board for instructions on how to submit attachments in GMIS. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit, Central Master Files address by **4:00 p.m. on or before Monday, February 3, 2020.**

A minimum of an original and the indicated number of copies of non-Internet attachments are required.

III. APPENDICES

A. Notice of Intent to Apply for Funding
B. GMIS Access Request Form
C. C1 Deliverable – Objective Descriptions (if applicable)
C2 Deliverable – Objective Allocations (if applicable)
D. Application Review Form
E. Role of the Medical Advisor
F. Program-Specific Attachments:
Attachment #1 – Public Health Impact Statement
Attachment #2 – Public Health Impact Statement from Local Health Districts
Attachment #3 – Biographical Sketch
Attachment #4 – Position Descriptions
Attachment #5 – Deliverable-Objectives and Work Plan
Attachment #6 – Letter of Documentation
Attachment #7 – Client Incentive Form

APPENDICES

Reimbursement Type
Select one of the options below:

☐ Monthly
OR
☐ Quarterly

NOTICE OF INTENT TO APPLY FOR FUNDING
Ohio Department of Health
Bureau of Maternal, Child and Family Health

ODH Program Title:
Sickle Cell – Statewide Family Support Initiative

ALL INFORMATION REQUESTED MUST BE COMPLETED.

Appendix A
Submission Required

See Due Date Below

New Applicants must submit the GMIS Access form with the Notice of Intent to Apply for Funding Form

County of Applicant Agency _____ **Federal Tax Identification Number** _____

Geographic Area Applying to Cover_____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

Type of Applicant Agency *(Check One)*
☐ County Agency ☐ Hospital ☐ Local Schools
☐ City Agency ☐ Higher Education ☐ Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

_____

Agency Contact Person Name and Title _____

Telephone Number _____ **E-mail Address**_____

_____ _____
Agency Head (Print Name) **Agency Head (Signature)**

Please note that the agency head listed above must match the agency head listed in GMIS. Unless a new agency, NOIAF's will not be accepted if name doesn't match what is listed in GMIS. If the agency head needs updated in GMIS, please include a letter on agency letterhead outlining the change. The new agency head's signature will be accepted with receipt of the update letter.

Does your agency have at least two staff members who have been trained in and currently have access to the ODH GMIS system? ☐ YES ☐ NO

If yes, no further action is needed.

If no, ODH Grants Services Unit staff will email the GMIS reference guide to the email addresses listed on the GMIS Access Request form.

The NOIAF must be accompanied by the agency's Proof of Non-Profit status (if applicable) and Proof of Liability Coverage (if applicable). Potential applicants and current subrecipients are required to set-up and maintain their current supplier information in the State of Ohio Supplier Portal. This information includes, but is not limited to, Electronic Funds Transfer (EFT), 1099 Form and current address.

This information must be set-up and maintained in the following website: http://supplier.ohio.gov/

Note: Subrecipients future payments will be held if the agency receives a paper check due to the EFT information not being properly maintained in the supplier portal.

Forms are only required for NEW AGENCIES or if UPDATES are needed for current agencies. THE NOIAF AND REQUIRED FORMS MUST BE EMAILED TO cheryl.jones@odh.ohio.gov BY January 07, 2020.

NOTE: NOIAF's will be considered late if any of the required forms listed above are not received by NEW AGENCIES by the due date. NOIAF's considered late will not be accepted.

Appendix B

If new applicant, this form must be submitted with the Notice of Intent to Apply for Funding Form.

GMIS User Access, Access Change or Deactivation Request

One request per person. Requests will only be honored when signed by your **Agency Head** or **Agency Financial Head** and complete**.** In addition, if a user leaves your agency, you are to notify ODH so that their account is rendered inactive and submit a form for the replacement. The user will receive his/her username and password via e-mail once the request is processed. *Refresher guides can be found on the ODH web site: https://odh.ohio.gov/wps/portal/gov/odh/about-us/funding-opportunities/ODH-Grants/. ODH Grants Page – "GMIS Training Resource" Section.*

Date: _____

Check the type of access and complete the information requested: [ ] New Agency – Needs GMIS Access

[ ] New Employee - needs GMIS Access. Effective Date of Activation: _____

[ ] Existing Employee - New GMIS User or GMIS User Access Change. Effective/Change Date: _____

[ ] Deactivation – User no longer needs access to ODH Application Gateway/GMIS 2.0 or GMIS 2.0 only:

Effective Date of Deactivation (ODH Application Gateway/GMIS 2.0): _____

Or **Effective Date of Deactivation (GMIS 2.0 access only): _____**

Agency Name & Address:_____

_____

Employee Name (no nicknames):

Employee Job Title:

Employee Office Phone Number:

Employee Office Fax Number:

Employee Office Email Address:

User Access Section: Please check all that applies and enter requested information:

Email Notifications: [ ] Yes [ ] No

GMIS Project Number(s) user needs access to: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Authorization Signature for User Access/Change/Deactivation:

_____ _____

Signature of Agency Head or Agency Financial Head **Printed Name of Agency Head or Agency Financial Head**

To be completed by Grants System Officer ONLY - Date Received: **Date Processed:**

Deliver Requests to Karen Tinsley, Grants System Officer, 614-644-7546
Mail: ODH/OFA, 35 E. Chestnut St.,4th Floor, Columbus, Ohio 43215 *Or*
Scan & Email: karen.tinsley@odh.ohio.gov

Appendix C1

Name of Subgrant Program: Sickle Cell - Statewide Family Support Initiative
Budget Period: July 1, 2020 to June 30, 2021
# of Deliverables: 12
Use Budget Justification Scenario #: 3

_____Base and Deliverables
__X__ Deliverables Only

Deliverable - Objective 1: Ensure statewide sickle cell services are available to Ohioans
Total Amount Available: $15,250.00

- **Deliverable 1.1 -** By June 30, 2021, the subrecipient shall have an identifiable, functional (staffed) program organized for and capable of ensuring the provision of **statewide** public and professional education, awareness and community engagement activities (adults) related to sickle cell disease, sickle cell trait and other hemoglobinopathies. The subrecipient will also be expected to register with the predominant information and resource agency in the state. Reimbursement for this deliverable is based is $1,320.83 per month or $3,962.50 per quarter *(based on reimbursement type)*. Total reimbursement for this deliverable is not to exceed $15,850.00 per subrecipient.

Deliverable - Objective 2: Implement and Promote Statewide Outreach and Awareness Messages/Campaigns
Total Amount Available: $23,000.00

- **Deliverable 2.1 -** By June 30, 2021, the subrecipient will implement and promote a minimum of one (1) statewide outreach and awareness message/campaign, *per month*, utilizing electronic and/or print mediums to increase the visibility of sickle cell services and engagement resources in Ohio. Reimbursement for this deliverable is $1,916.67 per month or $5,750.00 per quarter *(based on reimbursement type*). Total reimbursement for this deliverable is not to exceed $23,000.00 per subrecipient.

  NOTE: *Messages/campaigns for hemoglobinopathies must be prior approved as per ownership copyright guidelines. Reference Section I – Application Summary and Guidance, W- Ownership Copyright (page 11) for more information.*

Deliverable - Objective 3: Implement/Participate in Education and/or Awareness Events Targeting the Public
Total Amount Available: $13,500.00

- **Deliverable 3.1 -** By June 30, 2021, the subrecipient will **i**mplement/participate in a minimum of twelve (12) education and/or awareness events to the general public/community (adults) to increase visibility of Ohio sickle cell services and resources. This includes, but is not limited to, select Ohio Annual Health/Cultural Festivals and Events. Twenty-five percent (25%) of the education and/or awareness events must also include participation in select National Health National Health Observance Months *(e.g., April/National Minority Health Month; May/National*

Stroke Awareness Month; June/World Sickle Cell Day; November/American Diabetes Month) to highlight hemoglobinopathies and their association/link with other health concerns ($5,500.00). Reimbursement under this deliverable includes, but is not limited, to staff preparation and participation time, staff travel, registration and/or booth rental costs (if applicable) and data reporting. Total reimbursement for this deliverable is not to exceed $13,500.00 per subrecipient.

NOTE: *Excludes September/Sickle Cell Month and Sickle Cell Sabbath activities*

Deliverable - Objective 4: Implement/Participate in Education and/or Awareness Events Targeting Professionals
Total Amount Available: $10,000.00

- **Deliverable 4.1 -** By June 30, 2021, the subrecipient will implement/participate in **statewide** education and/or awareness events targeting professionals (including professional associations and/or organizations) to increase the visibility of sickle cell services and resources in Ohio. Reimbursement for this deliverable is up to $800.00 per event and includes, but is not limited, to staff preparation and participation time, staff travel, registration and/or booth rental costs (if applicable) and data reporting. Total reimbursement for this deliverable is not to exceed $8,000.00 per subrecipient.

- **Deliverable 4.2 -** By June 30, 2021, subrecipient staff *(applicable core team staff*) may request travel to a National Sickle Cell Conference (e.g., Sickle Cell Disease Association of America, Inc. National Convention - SCDAA) to present an **accepted abstract** for oral and/or poster presentation. **Abstract topic(s) for submission must be related to services/activities/programs that are currently funded by ODH**. For accepted abstracts (1) a copy of the final abstract must be submitted to the ODH Sickle Cell Program Coordinator prior to submission and (2) out-of-state travel expenditures for one (1) subrecipient core team staff member will include allowable travel and expense reimbursements as outlined in the OBM Travel Rules. The OBM Travel Rules can be found at http://ohiosharedservices.ohio.gov/TravelExpense/). Total reimbursement for this deliverable is not to exceed $2,000.00 per subrecipient.

  NOTE: *This is a select deliverable (Deliverable 4.2). If an abstract for poster and/or oral presentation is not submitted or accepted, the subrecipient may request that the funds be adjusted between deliverable line items. Budget revisions to adjust funding between select deliverable line items must be pre-approved (in writing) by ODH prior to submission of the revised GMIS budget and budget justification narrative.*

Deliverable - Objective 5: Administrative Oversight and Subgrant Funding to the Ohio Sickle Cell Affected Families Association
Total Amount Available: $8,000.00

- **Deliverable 5.1** - By June 30, 2021, the subrecipient will provide administrative oversight to the Ohio Sickle Cell Affected Families Association (OSCAFA) to distribute subgrant-funding for eligible Adult Sickle Cell Affected Family Support Groups (ASCAFSGs) to implement a minimum of one (1) capacity building activity in each of the six (6) ODH defined multi-county sickle cell service regions. Reimbursement for this deliverable is $6,000.00 allocated to the OSCAFA. Total reimbursement for this deliverable is not to exceed $8,000.00 per subrecipient.

Deliverable - Objective 6: Ensure Empowerment Resources for Adults Living with Sickle Cell Disease
Total Amount Available: $6,500.00

- **Deliverable 6.1 -** By June 30, 2021, the subrecipient will ensure that empowerment resources are available to adults living with sickle cell disease. This deliverable includes three (3) separate activities: (a) administration of the Empowerment Scholarship Fund (ESF) to provide scholarship assistance to eligible individuals and/or families impacted by sickle cell disease to attend sickle cell related educational events, (b) implementation of an Empowerment Event(s) for Adults (and young adults) Living with Sickle Cell Disease and (c) distribution of Client Incentives (gas cards ONLY) to clients/consumers for completion of or participation in an approved ODH Sickle Cell Program and/or subrecipient activity. Reimbursement for this deliverable is as follows:

Activity/Service/Program	Maximum Reimbursement
a. Empowerment Scholarship Fund	$2,500.00
b. Empowerment Event	$3,000.00
c. Client Incentives (Maximum $25.00 per/gas card)	$1,000.00

Total reimbursement for this deliverable is not to exceed $6,500.00 per subrecipient.

NOTE: *The specifics of the ESF will be provided to the successful applicant subsequent to official award notification from ODH. The subrecipient will also be expected to provide documentation (**Attachment #7**) of the gas card incentive provided to clients/consumers.*

Deliverable - Objective 7: Participation on External Groups, Programs or Organizations Representing Sickle Cell
Total Amount Available: $1,500.00

- **Deliverable 7.1** - By June 30, 2021, subrecipient staff *(applicable core team staff)* will actively participate on a minimum of one (1) national, regional, and/or statewide group, program or organization *(external to the subrecipient agency)* that serves to represent the needs of individuals with hemoglobinopathies and increase visibility of sickle cell services and programs. Reimbursement for yearly membership fees to the Sickle Cell Disease Association of America (SCDAA), Inc. is an allowable cost under this deliverable ($500). Total reimbursement for this deliverable is not to exceed $1,500.00 per subrecipient.

  NOTE: *The subrecipient will be expected to serve (through membership) as the SCDAA-Ohio state-lead.*

Deliverable - Objective 8: Plan and Implement a Statewide Sickle Cell Sabbath Event
Total Amount Available: $3,750.00

- **Deliverable 8.1** - During the state designated Sickle Cell Sabbath (SCS) weekend (September 2020), the subrecipient will plan and implement a minimum of one (1) **statewide** SCS activity, in coordination and collaboration, with **statewide** faith-based leaders/headquarters. Total reimbursement for this deliverable is not to exceed $3,750.00 per subrecipient.

Deliverable - Objective 9: Procurement of Educational Materials to Maintain a Statewide Hemoglobinopathy Clearinghouse and Resource Center
Total Amount Available: $2,500.00

- **Deliverable 9.1 -** By June 30, 2021, the subrecipient will purchase and maintain (clearinghouse and resource center) hemoglobinopathy education materials for distribution to public, professional and patient/client audiences in the state. Education materials must be current, of professional quality, culturally, age, language and literacy appropriate and available upon request. This deliverable includes materials that are purchased/printed through external vendors and internal departmental printing costs. The subrecipient will also be expected to develop and distribute an informative document (e.g., brochure) that outlines available hemoglobinopathy services/activities/programs. Total reimbursement for this deliverable not to exceed $2,500.00 per subrecipient.

  NOTE: *All new and existing materials developed/revised by the subrecipient under Deliverable 9.1 must follow the requirements for ownership copyright. Reference Section I – Application Summary and Guidance, W- Ownership Copyright (page 11) for more information.*

Deliverable - Objective 10: Staff Professional Development
Total Amount Available: $1,500.00

- **Deliverable 10.1 -** By June 30, 2021, subrecipient staff (*applicable core team staff)* will complete a minimum of two (2) professional development and/or in-service trainings related specifically to cultural, linguistic, health literacy and/or health communication appropriate service delivery. Total reimbursement for this deliverable not to exceed $500.00 per subrecipient.

  NOTE: *Includes online educational opportunities. Subrecipient agency mandated professional development and/or in-service trainings related specifically to cultural, linguistic, health literacy and/or health communication appropriate service delivery may be also count as one (1) of the two (2) minimum requirements.*

- **Deliverable 10.2 -** By June 30, 2021, subrecipient staff *(applicable core team staff)* will complete the Cincinnati Hemoglobinopathy Counselor Training Course. This deliverable requirement applies to subrecipient staff as follows: (a) NEW subrecipient staff within one year of employment and (b) EXISTING subrecipient staff with prior attendance greater than six (6) years. Total reimbursement for this deliverable is not to exceed $1,000.00 per subrecipient.

  NOTE: *This is a select deliverable (Deliverable 10.2). If the requirements for this deliverable have been met or are N/A, the subrecipient may request that the funds be adjusted between deliverable line items. Budget revisions to adjust funding between deliverable line items must be pre-approved (in writing) by ODH prior to submission of the revised GMIS budget and budget justification narrative.*

Deliverable - Objective 11: Data Collection and Reporting
Total Amount Available: $2,450.00

- **Deliverable 11.1 -** By June 30, 2021, the subrecipient will report progress on program performance measures utilizing the Program Performance Report (PPR). The PPR must be submitted electronically in GMIS, either monthly or quarterly *(based on reimbursement type),* in the format specified by ODH. Refer to the Solicitation for monthly or quarterly due dates. Reimbursement for this deliverable is $50.00 per month or $150.00 per quarter. Total reimbursement for this deliverable is not to exceed $600.00 per subrecipient.

  NOTE: *The format for submission of the PPR (and any required attachments) will be provided to the successful applicant subsequent to official award notification from ODH.*

- **Deliverable 11.2** – By April 30, 2021, the subrecipient will report subrecipient significant accomplishments and achievements utilizing the Annual Report Worksheet (ARW). The ARW must be submitted electronically in GMIS in the format specified by ODH. Total reimbursement for this deliverable is not to exceed $500.00 per subrecipient.

  NOTE: *The format for submission of the ARW (and any required attachments) will be provided to the successful applicant subsequent to official award notification from ODH.*

Deliverable - Objective 12: Subrecipient Communication with ODH
Total Amount Available: $2,800.00

- **Deliverable 12.1 -** By June 30, 2021, subrecipient staff *(applicable core team staff)* will participate in meeting formats as required/requested by ODH. The format of the meetings will include, but not limited to: conference calls, video conferences and/or in-person meetings (e.g., Sickle Cell Project Staff Meeting). Reimbursement for this deliverable is up to $700.00 per quarter. Total reimbursement for this deliverable is not to exceed $2,800.00 per subrecipient.

Name of Subgrant Program: Sickle Cell Statewide Family Support **Appendix C2**

Budget Period: 07/01/2020 to 06/30/2021

# of Deliverables: 12

Use Budget Justification Scenario #: 3

____ Base and Deliverables

_X__ Deliverables Only

	Deliverable- Objective 1 Deliverable 1.1 Ensure statewide sickle cell services are available to Ohioans	Deliverable- Objective 2 Deliverable 2.1 Implement and Promote Statewide Outreach and Awareness Messages/Campaigns	Deliverable- Objective 3 Deliverable 3.1 Implement/Participate in Education Events Targeting the Public	Deliverable- Objective 4 Deliverable 4.1 Implement/Participate in Education Events Targeting Professionals	Deliverable- Objective 4 Deliverable 4.2 Implement/Participate in Education Events Targeting Professionals	Deliverable- Objective 5 Deliverable 5.1 Administrative Oversight and Subgrant Funding to the Ohio Sickle Cell Affected Families Association
Ohio Sickle Cell and Health Association	$15,250.00	$23,000.00	$13,500.00	$8,000.00	$2,000.00	$8,000.00

	Deliverable- Objective 6 Deliverable 6.1 Ensure Empowerment Resources for Adults Living with Sickle Cell Disease	Deliverable- Objective 7 Deliverable 7.1 Participate on External Groups, Programs or Organizations Representing Sickle Cell	Deliverable- Objective 8 Deliverable 8.1 Plan and Implement a Statewide Sickle Cell Sabbath Event	Deliverable- Objective 9 Deliverable 9.1 Procure Educational Materials to Maintain a Statewide Clearinghouse and Resource Center	Deliverable- Objective 10 Deliverable 10.1 Staff Professional Development	Deliverable- Objective 10 Deliverable 10.2 Staff Professional Development
Ohio Sickle Cell and Health Association	$6,500.00	$1,500.00	$3,750.00	$2,500.00	$500.00	$1,000.00

	Deliverable- Objective 11 Deliverable 11.1 Data Collection and Reporting	Deliverable- Objective 11 Deliverable 11.2 Data Collection and Reporting	Deliverable- Objective 12 Deliverable 12.1 Subrecipient Communication with ODH	Total
Ohio Sickle Cell and Health Association	$1,200.00	$500.00	$2,800.00	$90,000.00

Appendix D

SFY 2021
APPLICATION REVIEW FORM

APPLICANT AGENCY: _____TOTAL PTS.: _____

☐ Approval and funding of application as submitted (no program special conditions)

☐ Approval and funding of application with special conditions. Please list conditions below:

_____

_____

_____

(Attach additional page)

☐ Disapproval of application as submitted. Please state reason(s) below:

_____

_____

_____

(Attach additional page)

_____

Print Name of Reviewer Signature Date

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

APPLICANT AGENCY: _____ **PROJECT #:** _____

REVIEWER NUMBER: _____ **REVIEW DATE:** _____

TOTAL AMOUNT OF FUNDS REQUESTED: _____ **ODH FUNDING ALLOCATION:** _____

Instructions: Review the grant application carefully. For each of the sections (1-7) listed below, record the appropriate point value in the Reviewers Score Column. Individual section scores should not exceed the maximum points. Strengths/Weaknesses and Special Conditions should be recorded in the appropriate areas.

	Max	Reviewer Score	Comments: Strengths/Weaknesses
Section 1. *Public Health Impact Statement Summary* (not to exceed one page)			
Applicant identifies the Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities.	**1**		
Applicant describes the demographic characteristics of the target population and the geographic area in which they live.	**2**		
Applicant includes a summary of the services to be provided or activities to be conducted.	**1**		
Applicant includes a plan to coordinate and share information with appropriate local health district(s).	**1**		
Public Health Impact Statement Summary Total	**5**		
Public Health Impact Statement Summary Special Condition(s):			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 2. *Formatting Requirements*			
Applicant properly labeled each item of the application packet (*e.g. Budget Narrative, Program Narrative).*	**2**		
Applicant uses1.5 spacing with one-inch margins for each section.	**2**		
Applicant submits the program and budget narratives in portrait orientation on 8 ½ by 11 paper.	**1**		
Applicant numbers all pages (print on one side only).	**1**		
Applicant does not exceed the maximum seventeen (17) pages in the Program Narrative section (**excludes** appendices, attachments, budget and budget narrative).	**2**		
Applicant uses a 12-point font.	**1**		
Applicant completes and submits forms in the format provided by ODH.	**1**		
Formatting Requirements Total	**10**		
Formatting Requirements Special Condition(s):			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 3. *Primary Reason and Justification Pages*			
Applicant provides a budget justification narrative outlining how the deliverable(s) will be met.	**5**		
Applicant provides a budget justification narrative that matches the budget in GMIS.	**3**		
Applicant includes the required certification language on the budget justification narrative. Budget justification narrative is also signed by the agency head.	**2**		
Applicant submits in GMIS a biographical sketch for all core team staff working on project deliverables. Program staff are well qualified by training and/or experience for their roles in the program. (**Attachment #3**).	**5**		
Applicant submits position descriptions for all core team staff in which a biographical sketch is submitted. (**Attachment #4).**	**5**		
Primary Reason and Justification Pages Total	**20**		
Primary Reason and Justification Pages Special Condition(s):			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 4. Project Narrative: *Executive Summary* (not to exceed 2 pages)			
Applicant identifies the target population, services and programs to be offered.	**4**		
Applicant identifies what agency or agencies will provide those services.	**2**		
Applicant defines the burden of health disparities and health inequities.	**2**		
Applicant describes the public health problem(s) that the program will address.	**2**		
Executive Summary Total	**10**		
Executive Summary Special Condition(s)**:**			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 5. *Description of Applicant Agency/Documentation of Eligibility/Personnel* (not to exceed 5 pages)			
Applicant briefly discusses the applicant agency's eligibility to apply.	**2**		
Applicant summarizes the agency's structure as it relates to this program and, as the lead agency, how it will manage the program.	**3**		
Applicant describes the capacity of the organization, its personnel and contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.	**5**		
Applicant notes any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant. Describes plans for hiring and training, as necessary.	**1**		
Applicant delineates **all** personnel who will be directly involved in program activities.	**2**		
Applicant describes the relationship between program staff members, staff members of the applicant agency and other partners and agencies that will be working on this program.	**2**		
Description of Applicant Agency/Documentation of Eligibility/Personnel Total	**15**		
Description of Applicant of Agency/Documentation of Eligibility/Personnel Special Condition(s):			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 6. Project Narrative: *Problem/Need* (not to exceed 5 pages)			
Applicant identifies and describes the local health status concern(s) that will be addressed by the program.	**5**		
Applicant only restates national and state data if local data is not available.	**3**		
Applicant discusses the specific health status concerns that the program intends to address in terms of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators.	**10**		
Applicant explicitly describes segments of the target population who experience a disproportionate burden for the health concern or issue; or who are at an increased risk for the problem addressed by this funding opportunity.	**5**		
Applicant includes a description of other agencies/organizations, in the state, also addressing this problem/need.	**2**		
Problem/Need Total	**25**		
Problem/Need Special Condition(s):			

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
Section 7. Project Narrative: *Methodology Section* (not to exceed 5 pages, excluding Deliverable-Objectives and Work Plan)			
In narrative form, applicant identifies the program goals**, S.M.A.R.T.** process, impact or outcome objectives and activities and indicates how they will be measured to determine the level of success of the program.	**5**		
Applicant describes how program activities are designed to address health disparities and/or health inequities issues, if they have been identified.	**10**		
Applicant completes a Deliverable-Objectives and Work Plan (**Attachment #5)** to identify program objectives, activities, person responsible for the implementation of **each** activity and the start/finish completion dates for each activity.	**15**		
Applicant correlates the health disparities and health inequities issues described in the application with the Health Equity Goals and Strategies indicated on the GMIS Health Equity Module.	**Yes**	**No**	Verified, not scored
Methodology Total	**30**		
Methodology Section Special Condition(s):			
POINT VALUES (1-7)	**115**	**/115**	
TOTAL SCORES	**115**	**/115**	

Appendix D

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

APPLICATION REVIEW FORM
State Fiscal Year: July 1, 2020 to June 30, 2021

	Max	Reviewer Score	Comments: Strengths, Weaknesses
8. Additional Requirements/Documentation ***(To be completed by ODH Program Staff-No Point Value Assigned)***			
Applicant submits a Letter of Documentation from the Medical Advisor to be associated with the agency. **(Attachment #6)**	**Yes**	**No**	
Applicant lists Project Director as a "User" in GMIS on the Project Contacts page (must have GMIS access).	**Yes**	**No**	
Applicant completes and submits the Civil Rights Review Questionnaire – EEO Survey (a part of the Application Section in GMIS).	**Yes**	**No**	
Applicant completes and submits the Federal Funding Accountability and Transparency Act (FFATA) Form in GMIS.	**Yes**	**No**	
Applicant completes the GMIS Health Equity Module.	**Yes**	**No**	**Note:** There are some functionality issues in GMIS and this module may not function properly.
Applicant submits the Assurances (Federal and State Assurances) Form in GMIS.	**Yes**	**No**	
Applicant submits a current Independent Audit Report.	**Yes**	**No**	
Additional Requirements/Documentation Special Condition(s)			

Appendix E

SFY 2021
ROLE OF THE MEDICAL ADVISOR

ROLE

The purpose of the Medical Advisor is to provide guidance and leadership to the subrecipient core team staff regarding the provision of **statewide** education, awareness, community engagement activities for individuals (adults) and families at risk or affected by sickle cell disease, sickle cell trait and other hemoglobinopathies and the professionals who serve them.

RESPONSIBILITIES OF THE MEDICAL DIRECTOR/ADVISOR

Pursuant to the purpose of the ODH Sickle Cell Services Program, the Medical Advisor functions directly or consultatively as follows:

- Facilitate the medical, referral and follow-up process for patients/consumers diagnosed with a hemoglobinopathy;
- Serve as a consultant to subrecipient staff regarding interpretation of laboratory test results for hemoglobinopathies (if applicable);
- Provide medical expertise about hemoglobinopathies and represent the subrecipient, when appropriate, within the medical community;
- Review and approve (in accordance with ODH) educational presentations and materials;
- Provide education, upon request and as necessary, to statewide professionals/providers and the public on hemoglobinopathies;
- Attend ODH Medical Director/Medical Advisor meetings (as requested/required); and
- Serve as a liaison between the subrecipient and the community of individuals affected by hemoglobinopathies.

QUALIFICATIONS:

- Preferably, the medical advisor should be a board-certified hematologist with expertise in the management of persons with sickle cell disease and treatment-related complications.

- If the medical advisor is not a board-certified hematologist, at a minimum, he/she must be a licensed physician with experience/expertise in the management of persons with sickle cell disease.

TERM

The term of responsibility should be determined by the subrecipient project director and the medical advisor.

PROGRAM-SPECIFIC ATTACHMENTS

Attachment #1

SFY 2021
PUBLIC HEALTH IMPACT STATEMENT SUMMARY

Include:

Applicant agencies are required to submit a summary of the proposal to local health districts prior to submitting the grant application to ODH. The program summary, **not to exceed one page**, must include:

- The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities;
- A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) of the target population and the geographical area in which they live (e.g., census tracts, census blocks, block groups);
- A summary of the services to be provided or activities to be conducted; and
- A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of the grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards**.**

Sickle Cell Program Application Guidance: *Each response on the Public Health Impact Statement Summary should be referenced by the bullet point to which correspond.*

Submit the Public Health Impact Statement Summary as an upload in GMIS under the Program Narrative Section.

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment #2

SFY 2021
PUBLIC HEALTH IMPACT STATEMENT OF SUPPORT
FROM LOCAL HEALTH DISTRICTS

Include:

A statement of support was obtained from the following local health districts (*list below).* **Statements of support must be signed, dated and on official letterhead.**

1.
2.
3.
4.
5.

Include:

A statement of support was not obtained from the following local health districts *(list below).*

1.
2.
3.
4.
5.

Include:

Number of local (city and county) health districts in the state: _____

Submit the Public Health Impact Statement(s) of Support obtained and not obtained from the local health districts as an upload in GMIS under the Program Narrative Section.

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment #3

SFY 2021

BIOGRAPHICAL SKETCH

Provide the following information for project deliverables core team staff.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME	POSITION TITLE

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, include postdoctoral training, if applicable)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY

A. Personal Statement

Briefly describe why your experience and qualifications make you particularly well-suited for your role in the project that is the subject of this application.

B. Positions and Honors

Begin with current position, then list in reverse chronological order, relevant previous employment and experience. List any honors under a separate category.

C. Professional Appointments and Membership

Begin with current appointments/memberships, then list in reverse chronological order, relevant professional appointments and/or memberships.

Submit Biographical Sketches as an upload in GMIS under the Program Narrative Section.

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment #4

SFY 2021
POSITION DESCRIPTIONS

Include:

The applicant must provide position descriptions for all core team staff in which a biographical sketch is submitted. A position description is not required for the Medical Advisor.

If a staff member has not been selected for a vacant position, a narrative description of the job information and responsibilities must be submitted in GMIS under the Program Narrative Section.

Submit Position Descriptions as an upload in GMIS under the Program Narrative Section.

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment #5

Ohio Department of Health
Bureau of Maternal, Child and Family Health
ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable – Objective 1: Ensure statewide sickle cell services are available to Ohioans

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverable	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 1.1 – By June 30, 2021, the subrecipient shall have an identifiable, functional (staffed) program organized for and capable of ensuring the provision of **statewide** public and professional education/awareness, community engagement activities (adults) related to sickle cell disease, sickle cell trait and other hemoglobinopathies. The subrecipient will also be expected to register with the predominant information and resource agency in the state.			1.1 (a) The identification of subrecipient staff who perform statewide sickle cell services/activities under this deliverable. 1.1 (b) The number of days per week/month/quarter that subrecipient staff are available to perform statewide sickle cell services/activities under this deliverable. 1.1 (c) Subrecipient is registered with the predominant information and resource referral agency (e.g. 2-1-1) in the state.	1.1 (a) Deliverable Reimbursement Form (DRF) 1.1 (b) DRF 1.1 (c) Documentation of registration submitted with DRF (by October 10, 2020)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable – Objective 2: Implement and Promote Statewide Outreach and Awareness Messages/Campaigns

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverable	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 2.1 - By June 30, 2021, the subrecipient will implement and promote a minimum of one (1) statewide outreach and awareness message/campaign, *per month*, utilizing electronic and/or print mediums to increase the visibility of sickle cell services and engagement resources in Ohio.			2.1 (a) The number of statewide outreach and awareness messages/campaigns implemented and promoted, *per month*, by the subrecipient utilizing electronic and print mediums. 2.1 (b) The audience numbers *(reach and frequency)* generated by statewide outreach and awareness messages/campaigns implemented and promoted, *per month*, by the subrecipient.	2.1 DRF and Data Format specified by ODH (e.g., Survey Monkey) 2.1 (b) Reach and frequency report submitted with DRF and Data Format specified by ODH (e.g., Survey Monkey)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable – Objective 3: Implement/Participate in Education Events Targeting the Public

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverable	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 3.1 - By June 30, 2021, the subrecipient will **i**mplement/participate in a minimum of twelve (12) education and/or awareness activities to the general public (adults) to increase visibility of Ohio sickle cell services and resources. This includes, but is not limited to, select Ohio Annual Health/Cultural Festivals and Events. Twenty-five percent (25%) of the education and/or awareness events must include participation in select National Health Observance Months *(e.g., April/National Minority Health Month; May/National Stroke Awareness Month; June/World Sickle Cell Day; November/American Diabetes Month)* to highlight hemoglobinopathies and their association/link with other health concerns.			3.1 (a) The number of education and/or awareness activities (including select Ohio Annual Health/Cultural Festivals and Events) provided by the subrecipient to the general public (adults). 3.1 (b) The number of select National Health Observance Month activities provided by the subrecipient to the general public (adults). 3.1 (c) The number of individuals (general public) who attend/participate in education and/or awareness events **and** National Health Observance Month activities provided by the subrecipient.	3.1 (a) DRF and Data Format specified by ODH (e.g., Survey Monkey) 3.1 (b) DRF and Data Format specified by ODH (e.g., Survey Monkey) 3.1 (c) DRF and Data Format specified by ODH (e.g., Survey Monkey)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 4: Implement/Participate in Education Events Targeting Professionals

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverable	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 4.1 - By June 30, 2021, the subrecipient will implement/participate in **statewide** education and/or awareness events targeting professionals (including professiona associations and/or organizations) to increase the visibility of sickle cell services and resources in Ohio.			4.1 (a) The number of statewide education and/or awareness events provided by subrecipient targeting professionals. 4.1 (b) The number of professionals who attend/participate in education and/or awareness events provided by the subrecipient.	4.1 (a) DRF and Data Format specified by ODH (e.g., Survey Monkey) 4.1 (b) DRF and Data Format specified by ODH (e.g., Survey Monkey)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 4: Implement/Participate in Education Events Targeting Professionals

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverable	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 4.2 - By June 30, 2020, the subrecipient may request travel to a National Sickle Cell Conference (e.g., SCDAA) to present an **accepted abstract** for oral and/or poster presentation. **Abstract topics for submission must be related to services/activities/programs that are currently funded by ODH**. For accepted abstracts (1) a copy of the final abstract must be submitted to the ODH Sickle Cell Program Coordinator prior to submission and (2) out-of-state travel expenditures for one (1) subrecipient core team staff member will include allowable travel and expense reimbursements as outlined in the **OBM Travel Rules*.** **NOTE:** *This is a select deliverable (Deliverable 4.2).*			4.2 (a) Abstract for poster and/or oral presentation accepted at National Conference. 4.2 (b) Subrecipient staff present (oral and/or poster) at National Conference.	4.2 (a) DRF 4.2 (b) DRF

*OBM Travel Rules can be found at: http://ohiosharedservices.ohio.gov/TravelExpense/

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 5: Administrative Oversight and Subgrant Funding to the Ohio Sickle Cell Affected Families Association

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 5.1 - By June 30, 2021, the subrecipient will provide administrative oversight to the Ohio Sickle Cell Affected Families Association (OSCAFA) to distribute subgrant-funding for eligible Adult Sickle Cell Affected Family Support Groups (ASCAFSGs) to implement a minimum of one (1) capacity building activity in each of the six (6) ODH defined multi-county sickle cell service regions.			5.1 (a) The number of eligible ASCAFSGs that request, apply and receive subgrant-funding. 5.1 (b) The number of subgrant-funded ASCAFSGs that implement a minimum of one (1) capacity building activity in each of the six (6) ODH defined multi-county service regions. 5.1 (c)The number of administrative meetings, site visits and/or conference calls implemented by the subrecipient with subgrant-funded ASCAFSGs.	5.1 (a) Program Performance Report (PPR) 5.1 (b) PPR 5.1 (c) PPR

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 6: Ensure Empowerment Resources for Adults Living with Sickle Cell Disease

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 6.1 - By June 30, 2021, the subrecipient will ensure that empowerment resources are available to adults living with sickle cell disease. This deliverable includes three (3)separate activities: (a) administration of the Empowerment Scholarship Fund, (b) implementation of an Empowerment Event(s) for Adults (and young adults) Living with Sickle Cell Disease, and (c) distribution of Client Incentives.			6.1 (a) The number of eligible individuals/families who request and receive scholarship assistance to attend a sickle cell educational event funded through the ESF. 6.1 (b) The number of individuals/families who complete and submit Outcome Report Forms as per ESF guidelines. 6.1 (c) The successful implementation of an Empowerment Event(s) for Adults (and young adults) Living with Sickle Cell Disease.	6.1 (a) PPR 6.1 (b) PPR 6.1 (c) DRF and Data Format specified by ODH (e.g., Survey Monkey)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 6: Ensure Empowerment Resources for Adults Living with Sickle Cell Disease

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 6.1 – (continued)			6.1 (d) The number of individuals in the target age groups *(age 16-21 and > than 21 years of age)* who attend the Empowerment Event. 6.1 (e) The number of Client Incentives (gas cards) distributed clients/consumers.	6.1 (d) DRF and Data Format specified by ODH (e.g., Survey Monkey) 6.1 (e) Attachment #7 submitted with DRF

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 7: Participation on External Groups, Programs or Organizations Representing Sickle Cell

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 7.1 - By June 30, 2021, subrecipient staff *(applicable core team staff)* will actively participate on a minimum of one (1) national, regional, and/or statewide group, program or organization *(external to the subrecipient agency)* that serves to represent the needs of individuals with hemoglobinopathies and increase visibility of sickle cell services and programs.			7.1 (a) The number of statewide groups, programs or organizations that subrecipient staff have active participation on during the reporting year. 7.2 (b) The number and percent of meetings attended by subrecipient staff. 7.2 (c) The subrecipient is a member of the SCDAA. Inc.	7.1 (a) PPR and DRF 7.1 (b) PPR 7.2 (c) DRF

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 8: Plan and Implement a Statewide Sickle Cell Sabbath Event

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 8.1 – During the state designated Sickle Cell Sabbath (SCS) weekend (September 2020), the subrecipient will plan and implement a minimum of one (1) **statewide** SCS activity, in coordination and collaboration, with **statewide** faith-based leaders/headquarters.			8.1 The number of SCS activities implemented by the subrecipient, in coordination and collaboration, with statewide faith-based leaders/headquarters during the state-designated weekend.	8.1 DRF and Data Format specified by ODH (e.g., Survey Monkey)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 9: Procurement of Educational Materials to Maintain a Statewide Clearinghouse and Resource Center

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 9.1 - By June 30, 2021, the subrecipient will purchase and maintain hemoglobinopathy education materials for distribution to public, professional and patient/client audiences in the state. Education materials must be current, of professional quality, culturally, age, language and literacy appropriate and available upon request. This deliverable includes materials that are purchased through external vendors and internal departmental printing costs. The subrecipient will also be expected to develop and distribute an informative document (e.g., brochure) that outlines available hemoglobinopathy services/activities/programs.			9.1 (a) Educational materials are purchased, maintained and readily available for distribution by the subrecipient to statewide public, professional and patient/client audiences. 9.1 (b) Document developed that outlines available hemoglobinopathy services and/or programs	9.1 (a) DRF 9.1 (b) Approved document submitted with DRF by January 10, 2020 9.1 (c) Resource listing of educational materials submitted with PPR

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 10: Staff Professional Development

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 10.1 - By June 30, 2021, subrecipient staff *(applicable core team staff)* will complete a minimum of two (2) professional development and/or in-service trainings related specifically to cultural, linguistic, health literacy and/or health communication appropriate service delivery.			10.1 The number and percent of subrecipient staff *(applicable core team staff)* who complete the minimum requirement (two professional development and/or in-service trainings) related specifically to cultural, linguistic, health literacy and/or health communication appropriate service delivery.	10.1 PPR and DRF

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 10: Staff Professional Development

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 10.2 - By June 30, 2021, subrecipient staff *(applicable core team staff)* will complete the Cincinnati Hemoglobinopathy Counselor Training Course. This deliverable requirement applies to subrecipient staff as follows: (a) NEW subrecipient staff within one year of employment and (b) EXISTING subrecipient staff with prior attendance greater than six (6) years. **NOTE:** *This is a select deliverable (Deliverable 10.2).*			10.2 The number and percent of NEW and/or EXISTING subrecipient staff *(applicable core team staff)* who complete the Cincinnati Hemoglobinopathy Counselor Training Course.	10.2 PPR and DRF

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 11: Data Collection and Reporting

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 11.1 - By June 30, 2021, the subrecipient will report progress on program performance measures utilizing the Program Performance Report (PPR). The PPR must be submitted electronically in GMIS, either monthly or quarterly *(based on the reimbursement type)*, in the format specified by ODH.			11.1 Subrecipient will report on program performance measures submitted as per deliverable requirements utilizing the PPR.	11.1 PPR submitted in GMIS (under Program Reports)

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 11: Data Collection and Reporting

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 11.2 – By June 30, 2021, the subrecipient will report subrecipient significant accomplishments and achievements utilizing the Annual Report Worksheet (ARW). The ARW must be submitted electronically in GMIS in the format specified by ODH.			11.2 Subrecipient will report significant accomplishments and achievements as per deliverable requirements utilizing the ARW.	11.2 ARW submitted in GMIS

Attachment #5

Bureau of Maternal, Child and Family Health

ODH Program Title: Sickle Cell – Statewide Family Support Initiative

DELIVERABLE-OBJECTIVES AND WORK PLAN
State Fiscal Year: July 1, 2020 to June 30, 2021

Sickle Cell Project: _____ Project #: _____

Deliverable- Objective 12: Subrecipient Communication with ODH

One deliverable, numbered sequentially, per page. Submit in format provided by ODH.

(1) Deliverables	(2) Work Plan Activities (Responsible Party)	(3) Timelines/ Start/Finish	(4) Performance Measures	(5) Data Source
Deliverable 12.1 - By June 30, 2021, subrecipient staff *(applicable core team staff)* will participate in meeting formats as required/requested by ODH. The format of the meetings will include, but not limited to: conference calls, video conferences and in-person meetings (e.g., Sickle Cell Project Staff Meeting).			12.1 The number of subrecipient staff *(applicable core team staff)* who attend/participate in meeting formats as per deliverable requirements.	12.1 (a) Subrecipient staff will required to sign ODH attendance sheet provided at in-person meetings to demonstrate attendance 12.1 (b) Subrecipient staff will be required to participate in roll-call for other meeting formats to demonstrate attendance

Attachment #6

SFY 2021
LETTER OF DOCUMENTATION

Include:

The applicant must identify and provide a letter of documentation from the Medical Advisor that will be responsible for providing guidance and leadership to the applicant agency regarding the implementation of the following three (3) grant priority areas: *statewide public and professional education, awareness and community engagement activities.*

- Preferably, the Medical Advisor should be a board-certified hematologist (on-site or off-site) with expertise in the provision of services related to hemoglobinopathies.

- If the Medical Advisor is not a board-certified hematologist (on-site or off-site), at a minimum, he/she must be a licensed physician with experience/expertise in the provision of services related to hemoglobinopathies.

The letter of documentation must be **signed, dated on official letterhead and document the role, responsibility and relationship of the Medical Advisor and the applicant agency**.

Refer to the Appendix section of the Solicitation for information on the role of the Medical Medical Advisor.

Submit the Letter of Documentation as an upload in GMIS under the Program Narrative Section.

Note: All attachments must clearly identify the authorized program name and grant application number.

Attachment #7

SFY 2021
CLIENT INCENTIVE FORM

Program Name: **Sickle Cell – Statewide Family Support** GMIS Program Code: SS

Project Name: _____

GMIS Project Number: _____

Sickle Cell Program Activity (Purpose): _____

_____

Project Period: **July 1, 2020 - June 30, 2021**

Gas Card Purchase and Distribution Form

Instructions: List all gas card purchased for use as incentives. All gas card incentives and incentive amounts are subject to Program approval and must follow ODH procedural guidelines and restrictions. Any unused gas cards at the end of the grant year will be subject to reimbursement in that amount to ODH.

Name of Store/Entity	Individual Gas Card Number	Gas Card Amount	Date Purchased	Recipient Name (Signature)	Date Given to Recipient